

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8324

1. PLACE OF DEATH

County Benton
Township Cooper
City Osage

Registration District No. 310
Primary Registration District No. 429a

File No. _____
Registered No. 61
St. _____ Ward)

2. FULL NAME

George Minkner

(a) Residence No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Husband of Roberta Minkner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 8 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Shepoygan, Wis
(STATE OR COUNTRY)

10. NAME OF FATHER William F Minkner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rutha Sayer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wisconsin
(STATE OR COUNTRY)

14. INFORMANT Roberta Minkner
(Address) Arlington Mo

15. FILED _____ 19 _____ Matthie David
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 30, 1930, to Mar. 26, 1930
that I last saw him alive on Mar 3, 1930, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
13 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS (Signed) W.A. Martin, M. D.

Mar 8, 1930 (Address) Albany, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Edgewood cemetery
Barren county DATE OF BURIAL May 27 1930

20. UNDERTAKER J.R. Shockey ADDRESS Albany Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 26 1930

